NC DMA Pharmacy Request for Prior Approval
Topical Anti-Inflammatory Medications

Recipient Information **DMA-0030**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: _____ 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐Other:_____

Clinical Information

Coverage of Elidel and Protopic 0.03%:

1. For areas OTHER than groin or face:- Has the patient failed 2 generic topical corticosteroids in the highest potency class and is the patient greater than 2 years of age? ☐ Yes ☐ No
2. For groin and face:-Has the patient failed 2 topical generic corticosteroids from preferred list in any potency class (see criteria for list) AND is patient greater than 2 years of age? ☐ Yes ☐ No
3. Does the patient have a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list (see criteria for list)? ☐ Yes ☐ No

Please list: _____

Coverage of Protopic 0.1%

4. For areas OTHER than groin or face:- Has the patient failed 2 generic topical corticosteroids in the highest potency class and is the patient greater than 18 years of age? ☐ Yes ☐ No
5. For groin and face:-Has the patient failed 2 topical generic corticosteroids from preferred list in any potency class (see criteria for list) AND is patient greater than 18 years of age? ☐ Yes ☐ No
6. Does the patient have a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list (see criteria for list)? ☐ Yes ☐ No

Please list: _____

Signature of Prescriber:_____ Date:_____

*Prescriber Signature Mandatory

Fax this form to CSC at: (855) 710-1964 Pharmacy PA Call Center: (866) 246-8505

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp